Central **LHIN**

Working Together for a Sustainable Future

2009-2010 Annual Report

Ontario
Local Health Integration Network

Ontario's LHINs: Working to Create an Integrated, Sustainable Health System

The Central Local Health Integration Network (LHIN) is one of 14 LHINs established by the Government of Ontario, through the *Local Health System Integration Act, 2006*, to plan, coordinate, integrate and fund health services at the local level.

Guided by local health care issues and opportunities, input from our health service providers and our communities, best practices and Ministry of Health and Long-Term Care priorities, LHINs play a fundamental role as health care in Ontario continues to evolve to ensure we are putting the needs of patients first, and focusing on quality care, delivered within an integrated and sustainable system.

LHINs have a legislated role to make local funding decisions and to ensure health service providers are accountable for the appropriate use of funds.

Our health service providers – including our hospitals, community support service agencies, long-term care homes, community health centres, mental health and addictions agencies and our community care access centre – are key partners for LHINs as we facilitate the effective and efficient integration of health services.

Together, we are making it easier for our residents to receive the best possible care, in the most appropriate setting, when they need it.

Visit www.lhins.on.ca for more information on how LHINs are making a difference.

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Message from the Chair and CEO

2009/10 has been a year of challenge, change and opportunity for Central LHIN, and by continuing to work with our health service providers, staff and Board of Directors, we have accomplished many things on behalf of our communities of which we can be proud.

We are most pleased about the development of our Integrated Health Service Plan (IHSP) 2010-2013: *Creating Caring Communities, Healthier People... Together*.

This new strategic service plan – which outlines four planning priorities – will provide Central LHIN with a framework for our activity and investments over the next three years.

It builds on the achievements of our first IHSP, and is informed by what we learned about our LHIN through our 2008 Health Service Needs Assessment and Gap Analysis Project. It also aligns with the priorities of the Ministry of Health and Long-Term Care in order to link provincial resources to local needs.

Guided by a steering committee of representatives from our hospitals, community-based and primary care providers and our community care access centre, hundreds of stakeholders provided input into our new IHSP.

It is through this plan that we remain committed to achieving our vision of caring communities, healthier people, by supporting a health care system that is there for our residents when they need it, now and in the future.

In 2009/10, we invested close to $85 million in incremental funding – additional to our base funding of over $1.6 billion – across the health system. Some other 2009/10 highlights, further detailed throughout this report, include:

- began the process to negotiate – for the first time ever – accountability agreements with our 46 long-term care providers,
- signed our Ministry-LHIN Accountability Amending Agreement with the Ministry of Health and Long-Term Care,
- lowered wait times for cancer surgeries, hip and knee replacements, and non-admitted, low and high acuity patients treated and released from the emergency department,
- recovered unspent budget surpluses of $10 million from our health service providers and reinvested these funds across the system to address other urgent local needs,
- observed an increased number of voluntary health service provider integrations, and
- invested $33.6 million through 53 Aging at Home projects to provide care and services to an additional 16,000 seniors in our LHIN.

Over the past year, Central LHIN continued to mature as an organization, which helped us to better support and work with our health service providers during this time of fiscal restraint and growth pressures in our communities.

We would like to thank our health service providers and other key stakeholders for partnering with us to make 2009/10 a year of further system achievements.

Thank you as well to the Central LHIN Board of Directors for their guidance and support, and our staff for their hard work and dedication to achieving positive outcomes over the past year.

We look forward to continued collaboration with our partners to meet our targets and improve access to care and services for residents in our communities.

Ken Morrison
Chairman of the
Board of Directors

Kim Baker
Chief Executive
Officer

Board of Directors

In accordance with the *Local Health System Integration Act, 2006*, LHINs operate as not-for-profit organizations governed by an appointed board of directors, and are bound by accountability agreements with the Ministry of Health and Long-Term Care.

Board members are appointed by Order-in-Council. New members are selected based on applications to the Public Appointment Secretariat, with all candidates assessed for the fit between skills and experience of the prospective appointee and the needs of each LHIN.

Over the past year, the Central LHIN Board has had a consistent complement of nine members. In March 2010, we welcomed one new member as another member's term expired in January 2010.

Kenneth A. Morrison, Chair
June 2, 2005 –
June 1, 2011
Newmarket

Arthur W. Walker, FCA, Vice-Chair
June 2, 2005 –
June 1, 2011
Bradford

Sandy Keshen, Board Secretary
June 2, 2005 –
June 1, 2011
Richmond Hill

Colin Benjamin
January 5, 2006 –
January 4, 2011
North York

Raksha Bhayana
May 17, 2006 –
May 16, 2011
Thornhill

Eugene Cawthray
May 17, 2006
– June 16, 2010
King City

John Langs
September 24, 2008
– September 23,
2011
Toronto

John Rogers
March 10, 2010
– March 10 , 2013
Keswick

Elaine Walsh
June 17, 2006
– June 16, 2010
Unionville

Monique Moreau
January 5, 2006
– February 4, 2010
Everett

Details on the Central LHIN Board of Directors can be found at www.centrallhin.on.ca

Caring Communities, Healthier People and Health System Sustainability

Central LHIN's mandate is to plan, coordinate, integrate and fund health services at the local level.

Through our IHSP 2010-2013 – which outlines the priorities we will focus on over the next three years – Central LHIN remains committed to achieving our vision of caring communities and healthier people, by supporting a health care system that is there for our residents when they need it, now and in the future.

This vision was first articulated in our strategic plan and supported by our first IHSP. The strategic plan is a visual depiction of Central LHIN's mission, vision and core values.

We believe a caring community is one that is truly engaged, where each of us – from our staff and Board of Directors to our health service providers and our residents – view ourselves as important contributors in working together to create a common vision for our health care system.

Central LHIN Strategic Plan
Vision
Caring Communities- Healthier People
Mission
Enable Access to an Integrated Health System for our Communities
Core Values – Making a Difference
• Collaboration/Partnership • System Responsiveness and Quality
• People/Community Focused • Openness and Transparency
Strategic Directions
Strategic Priorities
Creating a Caring Collaborative Environment
Service Provider Relationship Development
Building Community Confidence
Community Engagement
Establishing Local Health System Priorities
Integrated Health Service Plan Implementation
Facilitating Design of a Continuum of Care and Support
Coordination and Integration
Developing Central LHIN's Capacity to Deliver its Mission
Central LHIN Development
Enablers
• Information Technology/Information Management • Heath Human Resources
• Primary Care • Strategic Investment • Integration
The Ontario LHIN Mandate:
Be responsible for planning, coordinating, integrating and funding local health services

A look inside our LHIN

LHINs reflect the idea that communities know their own health needs and priorities best.

To achieve our goals, we are engaging with our communities, and working to develop strong, positive relationships with individuals and groups who have a stake in our health care system. This helps us respond to the unique needs of our diverse communities and support local decision-making.

Our activities and investments are also informed by what we know about the people who live in our LHIN – including ethnicity, age, income and education level – and the overall health of our population.

Growth, aging and diversity are three key population trends that continue to feature prominently for Central LHIN.

Growth outpacing the provincial average

Central LHIN is both the most populous and one of the fastest growing LHINs in the province.

More than 1.7 million people live in Central LHIN, which represents about 13.2% of Ontario's total population.

This number is increasing at a rapid pace. Our high population growth rate of 19.2% over the next 10 years will outpace Ontario's growth rate of 12.6% over the same period.

Aging equals increased demand for services

Central LHIN will experience greater-than-average population aging over the next 10 years. The 65+ age category is projected to grow from 212,949 to 323,669.

That is an additional 110,720 seniors, or a 52% increase. In contrast, the provincial population of seniors is projected to increase by 41.4% over the same period.

Both growth and aging pose significant challenges for our health service providers as they work to meet the increasing demand for care and services.

A mix of urban and rural communities

Central LHIN's boundaries include the northern section of Toronto, most of York Region and the southern part of Simcoe County.

According to the 2006 census, Central LHIN is the most populous of Ontario's 14 LHINs. However, geographically, we are the third smallest in size. Our population density is 40 times greater than that of Ontario as a whole.

The majority of our residents live in areas north of Toronto, commonly referred to as the "905."Approximately 70% of our population lives in North Toronto, Vaughan, Richmond Hill and Markham. Our LHIN has a significant rural region in the north, which can present challenges to residents when accessing services.

More diverse by the day

Central LHIN has the highest proportion – 47.9% -- immigrants in the province, and almost twice the provincial average of visible minorities – 42.1 % of our population identify themselves as visible minorities – and hence a higher percentage of people whose mother tongue is not French or English.

Aboriginal and Francophone communities

Central LHIN has a relatively small presence of Aboriginal/First Nations in our LHIN – about 0.4% of our population, or 7,000 people.

In the summer of 2009, a new, more inclusive definition of Francophone was adopted by the province.

As a result, Francophones are now defined as including those whose mother tongue is neither French nor English, but who speak French at home or who come from a place where French is an official language.

This change potentially increases our current proportion of Francophones from approximately 1% to 3.2%, or from about 17,000 people to about 56,000.

Overall, North Toronto, Markham and Vaughan are the areas where we face the greatest challenges providing culturally and linguistically appropriate services for diverse communities.

Health profile

Examining our LHIN's health profile helps us work towards our goal of reducing health disparities and enhancing access to health care in our LHIN by identifying populations that would benefit from focused initiatives.

Generally, our residents have a lower incidence of chronic diseases and conditions such as high blood pressure, diabetes, heart disease, arthritis and asthma than that of Ontario as a whole.

Within our planning areas however, there are variations in health status due to differences in social determinants of health such as education, unemployment and risk behaviours such as smoking and obesity, which have all been shown to play a role in health.

According to the Canadian Institute of Health Research, high-risk populations are groups of people that share characteristics – such as homelessness, single women living in poverty or lone-parent families – associated with high-risk of adverse health outcomes.

Two of our planning areas – South Simcoe / Northern York Region and North York West – have been identified as high-risk populations

from a population health standpoint. A higher number of the residents in these two planning areas face serious chronic diseases, as well as obstacles to accessing primary care, compared to other planning areas in the LHIN.

How planning areas help us meet local needs

As one way to aid in our planning activities at the local level, Central LHIN divided its geography into seven planning areas. These areas have varying sizes, age structures, economic conditions and social characteristics.

Because Central LHIN's planning areas are so different, each has its own unique challenges and needs that must be considered when planning at a system level.

Our *Population Factors by Planning Area* table illustrates some key population factors for each planning area.

Central LHIN Population Factors by Planning Area

	Ontario	Central LHIN	South Simcoe and Northern York Region	Central York Region	South East York Region	South West York Region	North York West Region	North York Central Region	North York East Region
Total Population 2008	12,986,332	1,651,681	113,257	204,207	465,683	230,536	237,884	276,973	123,141
% of LHIN Population in Planning Area			7%	12%	28%	14%	14%	17%	7%
% Population Aged 65+	14%	13%	11%	11%	10%	9%	15%	17%	14%
% Population Visible Minority	23%	42%	5%	9%	52%	23%	50%	38%	56%
% Population Immigrants	23%	48%	14%	21%	54%	45%	59%	56%	63%
% Population Francophone	4%	1%	1%	2%	1%	1%	1%	1%	1%
% Population Aboriginal	2.0%	0.4%	1.4%	0.8%	0.4%	0.1%	0.4%	0.2%	0.2%
% Population English Mother Tongue	68%	50%	88%	84%	42%	48%	43%	46%	42%
% Low Income Families	11%	9%	7%	5%	5%	4%	20%	13%	15%
% Single Parent Families	15%	15%	13%	12%	12%	10%	27%	17%	19%
% Population Aged 20+ with less than High School Education	25%	22%	28%	17%	19%	23%	39%	18%	18%

Source: KPMG Central LHIN Health Service Needs Assessment and Gap Analysis 2008

Our contribution to the health care system

Dollars and sense

Central LHIN is committed to transparent, responsive and accountable health spending. We work with our stakeholders to plan investments that put local health dollars where they are most needed, based on community priorities, to improve the accessibility, coordination, quality and efficiency of our local health system.

In 2009/10, Central LHIN allocated approximately $1.7 billion across a range of health programs.

We invest roughly $4.6 million dollars in our local health system every day, through our health service providers, which include:

- seven public and three private hospitals
- forty-six long-term care homes,
- thirty-five community support service providers,
- twenty-four mental health and addictions service providers,
- one community care access centre and
- two community health centres.

Drug benefits, independent health facilities, laboratories, ambulance services, public health and most physician services are funded directly by the province of Ontario.

Central LHIN 2009/10 Health Service Provider Funding Allocation	
Sector	**2009/10 Funding Allocation**
Operation of Hospitals	1,051,676,778
Grants for Municipal Taxation	224,925
Long-Term Care Homes	281,643,069
Community Care Access Centre	203,474,565
Community Support Services	36,960,752
Acquired Brain Injury	8,938,225
Assisted Living Services in Supportive Housing	19,436,492
Community Health Centres	7,105,587
Community Mental Health	57,928,353
Addictions Program	4,414,563
Total	**1,671,803,309**

Cross-LHIN collaboration

Collaboration between neighbouring LHINs will strengthen available health services and resources to improve efficiencies across LHIN boundaries.

In 2009/10, Central LHIN was part of an inter-LHIN working group, which developed principles to support a seamless provision of services across LHIN boundaries to ensure patients are provided with needed care and services no matter where they live.

More procedures, more beds, more timely care and services

Central LHIN residents benefited in the last year from an increase in the number of procedures performed by our health service providers, reductions in wait times and new services designed to ensure patients receive timely and responsive care in the most appropriate setting.

Wait time improvements in 2009/10

- ✓ Cancer surgery wait times *decreased* by 4.1%
- ✓ Hip replacement wait times *decreased* by 23.6%
- ✓ Knee replacement wait times *decreased* by 15.4%
- ✓ Number of high acuity patients treated within eight hours *increased* by 3.3%
- ✓ Number of low acuity patients treated within four hours *increased* by 2.8%

Initiation of new services

In 2009/10, Central LHIN added the following new services in our communities:

- ✓ **Sixty-four new interim beds** – 32 each – at Southlake Residential Care Village and York Central Hospital's long-term care facility to allow more seniors who no longer need acute care to be discharged from hospital to a more appropriate setting
- ✓ **Twenty-four dialysis machines** to enable the opening of the Vaughan Satellite Dialysis Unit. This $8 million investment is operated by York Central Hospital.
- ✓ **Four additional neonatal intensive care unit beds** – two each – at Markham Stouffville and York Central Hospitals to ensure more newborns can get better access to intensive care closer to home

Investing in additional procedures

In 2009/10 Central LHIN invested just over $24 million in one-time incremental funding, enabling our hospitals to perform:

- ✓ 4,044 *more* cataract surgeries
- ✓ 257 *more* cardiac procedures
- ✓ 1,100 *more* joint replacements
- ✓ 444 *more* cancer surgeries
- ✓ 18,718 *more* MRI hours
- ✓ 5,866 *more* CT hours
- ✓ 932 *more* general surgeries
- ✓ 154 *more* paediatric surgeries

Supporting local collaboration and integration

Progress on our mandate to improve service integration

Central LHIN is making progress to improve the sustainability of the health system by encouraging integrated service delivery and care models across sectors. Integrated models provide coordinated, accessible and high-quality health care that improves patient care, and makes service delivery more efficient.

Examples of local progress in 2009/10 towards this goal in our LHIN include:

Integration Name	Description/Partners	Integration Type	Central LHIN Planning Area
Humber River Regional Hospital Markham Stouffville Hospital Southlake Regional Health Centre North York General Hospital York Central Hospital	Regional consolidation of eye surgeries to two sites: Southlake Regional Health Centre in the North and North York General Hospital in the South of our LHIN	Voluntary	All Central LHIN planning areas
COTA Health and Homeward Mental Health Projects of Metro Toronto	Transfer of all operating funds and services from Homeward to COTA	Voluntary	North York Central and North York West
Palliative Care Network for York Region and Southlake Regional Health Centre	Transfer of pain and symptom management consulting services from Palliative Care Network to Southlake Regional Health Centre	Voluntary	South Simcoe, Northern York Region and Central York Region
York Durham Aphasia Centre and Ontario March of Dimes	Merge York Durham Aphasia Centre with Ontario March of Dimes	Voluntary	Central York Region, South Simcoe and Northern York Region
York Central Hospital and Canadian Mental Health Association of York Region	Transfer of mandate and funding of mental health vocational rehabilitation from York Central Hospital to Canadian Mental Health Association of York Region	Voluntary	Central York Region
Arts Carousel and PACE Independent Living	Amalgamate Arts Carousel mandate, programs and funding to PACE Independent Living	Voluntary	South West and South East York Region

For more on integration in Central LHIN, including *Guidelines for Identifying Integration Proposals*, visit the integration section of our website.

Governance resource and toolkit for voluntary integration

The *LHIN/Health Service Provider Governance Resource and Toolkit for Voluntary Integration Initiatives* was developed by Central LHIN, in partnership with four other LHINs, to support health service provider boards in developing strategies to work with one another and the LHIN on voluntary integration initiatives.

Rollout of this resource – available at www.centrallhin.on.ca – continued into 2009/10. This resource was also included as an appendix to the Ministry of Health and Long-Term Care's LHIN Guide to Good Governance, released in September 2009.

Building a Better Health System Through Shared Accountability

Accountability agreements

LHINs enhance system accountability for public funds through the development and signing of accountability agreements with our health service providers, and through our Ministry-LHIN Accountability Agreement with the Ministry of Health and Long-Term Care.

In 2009/10, Central LHIN:

- Developed a Long-Term Care Home Service Accountability Agreement template and began the process to negotiate agreements with our 46 long-term care providers
- Negotiated and signed a one-year extension to the 2008-10 Hospital Service Accountability Agreements with our seven public and three private hospitals
- Signed our Ministry-LHIN Accountability Amending Agreement, as work continues to develop our new Agreement, which will be known as the Ministry-LHIN Performance Agreement as of 2010/11.

These agreements support collaboration to enhance stability and accountability in the health system. They also support alignment of health services across the sectors, and are in line with LHIN and Ministry of Health and Long-Term Care priorities, helping us to build a better local health care system that emphasizes quality care, delivered within available resources.

Our accountability agreement performance for 2009/10

Our Ministry-LHIN Accountability Agreement defines the relationship and establishes mutual understanding between the Ministry of Health and Long-Term Care and Central LHIN in the delivery of local health services, and outlines performance indicators and targets to be met within a pre-defined time period. In 2009/10, we measured our impact through the following performance indicators:

Performance Indicator	LHIN 09/10 Starting Point	LHIN 09/10 Target	Most Recent Quarter 09/10	Annual Results	LHIN Met Target YES/NO
90th Percentile Wait Times for Cancer Surgery	49	49	54	47	YES
90th Percentile Wait Times for Cataract Surgery	100	100	111	102	YES
90th Percentile Wait Times for Hip Replacement	182	182	131	139	YES
90th Percentile Wait Times for Knee Replacement	182	182	159	154	YES
90th Percentile Wait Times for Diagnostic MRI Scan[1,2,3,4]	100	95	158	136	NO
90th Percentile Wait Times for Diagnostic CT Scan[3,4,5]	30	28	51	44	NO
Median Wait Time to Long-Term Care Home Placement -All Placements[6,7]	94	85	93	116	NO
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution[6,7,8]	13.06%	8.70%	15.35%	15.36%	NO
Proportion of Admitted patients treated within the LOS target of ≤ 8 hours[9]	24.00%	34.00%	23.33%	23.12%	NO
Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III[9]	77.00%	86.00%	81.03%	79.83%	NO
Proportion of Non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours[10]	86.00%	93.00%	89.70%	88.10%	NO

Target Assessment: YES = LHIN Met Target / Within Corridor or NO = LHIN Did Not Meet Target / Above Corridor

[1] Initial incremental wait time funding was reduced from previous years.
[2] One hospital reduced its hours of operation due to renovations.
[3] While Central LHIN experienced high growth, our hospitals operated to confirmed funded levels in order to achieve balanced budgets therefore demand outstripped capacity.
[4] Some hospitals were unable to fully utilize additional volumes as third quarter reallocation funding flowed late in the fiscal year.
[5] One hospital experienced additional urgent demands from their regional cardiac and cancer programs.
[6] Central LHIN has only 261 long-term care beds per 1,000 residents (85+ population) compared to the provincial average of 313 per 1,000 (85+). This represents a capacity gap of 1,441 beds.
[7] Compliance issues and outbreaks reduced our ability to access existing beds, resulting in 1,312 days lost to admission
[8] Improvement in data quality resulted in an increased but more accurate percentage of Alternate Level of Care (ALC) days. This correction resulted in an overall increase of 3% to total Central LHIN ALC days.
[9] Central LHIN emergency departments saw the largest provincial increase (14% or 34,710 visits) for high acuity patients. These patients typically required inpatient admission, therefore the increase in volume created challenges in meeting the targeted wait time of eight hours.
[10] Central LHIN continued to have the third best wait time in the province for low acuity patients. Performance for 2009/10 was impacted by the increase in volumes for high acuity patients, which resulted in higher wait times for those presenting with lower acuity levels.

Meeting our performance goals

Waiting for care when we are ill or need surgery can be frustrating. Lengthy wait times may also negatively affect our overall care experience and health outcomes.

That is why wait times remain both a provincial and Central LHIN priority.

Over the 2009/10 fiscal year, we have reduced wait times for cancer surgeries, and hip/knee replacements as well as low acuity visits to our emergency departments.

Additional funding allocations have enabled our providers to deliver more cataract, cardiac and hip/knee replacement procedures, as well as more cancer, paediatric and general surgeries.

In 2009/10, Central LHIN funded an additional $6.3 million in incremental funding for more MRI and CT hours, and invested in programs – through Aging at Home and the LHIN Urgent Priorities Fund –focused on providing interim beds and increasing system capacity to address alternate level of care pressures in our LHIN.

Central LHIN remains challenged in meeting our wait time targets for MRI, CT, alternate levels of care, median wait times to long-term care placement, as well as the emergency department wait time targets.

On a positive note, according to the most recent available data, Central LHIN has the third best rate of improvement in the province for wait times for all patients who are treated and then discharged from the emergency department.

This is particularly positive given Central LHIN hospitals have been faced with the highest growth in the number of very sick people that are showing up in our emergency departments needing emergency care.

Hospitals in Central LHIN have also achieved this improvement without losing focus on patient safety and quality of care. The number of people discharged from our emergency departments that need to return within seven days – a key indicator of the appropriateness of the care received – continues to be the lowest in the province.

Some of the issues we faced over the last fiscal year in Central LHIN include an aging population, lack of long-term care bed capacity, and growing demand for services that at times outstripped capacity.

Central LHIN remains focused on addressing these issues by continuing to work with our health service providers to share best practices and find efficiencies, and to focus funding towards building our post-hospital bed capacity.

See page 12 for more on our emergency department and alternate level of care results and initiatives.

Investing in additional procedures

Over the past year, we invested just over $24 million of incremental funding for additional procedures in Central LHIN hospitals including:

Procedure	Incremental* funding	Resulting in an additional
Cataracts	$2,826,000	4,044 cataract surgeries
Cardiac	$1,127,669	257 cardiac procedures
Hip and Knee Joint Replacements	$8,526,900	1,100 joint replacements
Cancer	$3,948,028	444 cancer surgeries
MRI	$4,866,600	18,718 hours
CT	$1,471,600	5,886 hours
General	$1,282,600	932 general surgeries
Paediatric	$191,600	154 pediatric surgeries
TOTAL	**$24,240,997**	

For April 1, 2009-March 31, 2010

*One-time funding allocated to a hospital to provide a certain number of additional procedures within a specific year.

Working with our health service providers

Increasing CT capacity – Central LHIN continues to work with the Wait Times Strategic Planning Group to share best practices and address system issues at the local level to improve our CT results.

Key initiatives we anticipate will have positive impacts in the next fiscal year are a Ministry-sponsored initiative at Southlake Regional Health Centre to increase efficiency in this area, and the introduction of a new CT machine at Stevenson Memorial Hospital in Alliston.

High volume cataract centres –Two years ago, an Ophthalmology Working Group was struck to create the vision and strategy for consolidation of eye surgeries in Central LHIN.

In March 2010, the work of this group culminated in the creation of two high-volume cataract centres. This integrated regional model is streamlining referrals, improving access to services and reducing wait times for eye surgery.

Total Joint Assessment Centre – In 2009/10, Central LHIN continued to fund this integration initiative between Markham Stouffville, North York General and York Central Hospitals to streamline referrals and pre-surgical assessments for patients with hip or knee joint pain.

This collaborative model reduces wait times, improves quality of care through enhanced coordination and service delivery and gives patients more choice.

In the past three years, the Total Joint Assessment Centre has seen an increase in patient participation and success of this program as evidenced through shorter wait times for patients who participated in the program when compared to those who did not.

As Central LHIN continues to monitor and track our progress towards our targets, and to work with our health service providers to develop and implement collaborative and self-sustaining solutions, we remain confident that residents of our LHIN will continue to benefit from reduced wait times.

LHIN Initiatives in Support of Government Priorities

Reducing the time people spend waiting in the emergency department for care is a complex issue that has become both a provincial and a Central LHIN priority.

Improving access in the emergency department depends in part on a hospital's ability to either admit patients to its acute care beds, or to discharge patients to appropriate destinations such as other care settings or home in the community with home care.

To address this issue, we are focused on improving emergency department efficiency and capacity, *and* reducing the time spent in acute care beds waiting for alternate levels of care.

Enhancing emergency department capacity

Central LHIN's emergency department and alternate level of care strategy aligns with that of the Ministry of Health and Long-Term Care.

In 2009/10, Central LHIN invested in programs under the Aging at Home strategy, and participated in two provincial programs designed to help meet the following provincial targets:

- having lower acuity patients seen and treated within four hours and
- having higher-acuity patients, including admitted patients, treated in the emergency department within eight hours.

Pay for Results (Year 2)

In 2009/10, Central LHIN was allocated $7.8 million for Year 2 of the provincial Emergency Department Pay for Results program.

This funding was directed to help reduce emergency department length of stay and improve patient satisfaction at: Humber River Regional Hospital (Church and Finch sites), Markham Stouffville Hospital, North York General Hospital, Southlake Regional Health Centre and York Central Hospital.

The Pay for Results Year 2 outcomes attained by Central LHIN and its service providers demonstrated positive trends for all patients requiring emergency department services but not admission to a hospital bed.

For example, the rate of improvement of high-acuity patients treated within eight hours was 3.3%, ranking sixth best in Ontario. This accomplishment was achieved despite the Central LHIN having the largest increase in high-acuity patients in the province.

Similar positive results were attained in the proportion of low-acuity patients treated within four hours, with continued efforts throughout the year culminating in the Central LHIN achieving the provincial target of 90% in Q4.

Emergency Department Process Improvement Program (ED-PIP Wave 2)

In 2009/10, York Central Hospital and Humber River Regional Hospital participated in the second phase of this provincial initiative, which was introduced to address the challenges patients face in accessing timely emergency department care. Objectives included:

- shortening emergency department waits,
- improving patient satisfaction,
- improving hospital work environment and
- building capacity for continuous quality improvement and sharing of best practices.

Both participating hospitals are implementing many of the process improvement initiatives that arose through their program involvement.

Reducing emergency department demand

In 2009/10, Central LHIN funded the following two projects to reduce wait times and prevent avoidable emergency department admissions:

Emergency Department Diversion Program for Mental Health and Addictions
Lead: North York General Hospital
Highlighted as a "success" story in the most recent Ontario Health Quality Council Report, this initiative focused on improving the coordination of care delivery between acute care and community-based supports.

When a patient with a mental health issue visits the emergency department but does not need to be admitted, a mental health team initiates a referral to a community-based crisis worker who meets with the patient in the emergency department to assess the crisis, develop a support plan and link the patient to immediate crisis management services in the community.

According to the pilot project results:

- 83% of those treated said they would seek alternate services rather than emergency care if another mental health crisis occurred,
- 77% of clients had no return emergency department visits and
- more than 50% of referred clients may have been admitted to inpatient beds if this program had not been available.

Nurse-led Outreach Teams
Lead: Southlake Regional Health Centre, York Central Hospital, Humber River Regional Hospital
In 2009/10, Central LHIN funded three nurse-led outreach teams. Led by a nurse practitioner, nurse-led outreach teams include health care professionals with geriatric expertise. The teams reduce avoidable emergency department transfers and hospital admissions by building long-term care home expertise so residents have access to timely care in their own home.

Services provided include preventative care, staff education, telemedicine consultations, assessment, treatment, and care coordination.

Reducing alternate level of care demand

When patients no longer need acute care in our hospitals, they often remain in acute care beds while they wait to be discharged or transferred. They need an "alternate level of care" such as long-term care or rehabilitation. This often leads to longer wait times in the emergency department as patients wait to be admitted to a bed in the hospital.

In 2009/10, Central LHIN continued to work with our health service providers and the Ministry of Health and Long-Term Care to build capacity in our local health system to ensure that people get the care they need…in hospital, in a rehabilitation or long-term care setting, in the community or at home.

Here are some of the enhancements we have made in the system in the past year to improve the alternate level of care situation.

Home First
Lead: Central Community Care Access Centre
The Home First program was funded by Central LHIN as a pilot program commencing in November 2009. The purpose of the program – which served about 60 clients by the end of the 2009/10 fiscal year – is to relieve alternate level of care pressures through the provision of enhanced community-based services so clients waiting in acute care beds for alternate levels of care can be safely discharged to their home.

Services include assessments, care coordination, nursing, social work, occupational therapy, physiotherapy, personal support services and nutrition. This pilot program is currently serving clients at North York General Hospital and may be expanded in 2010/11.

64 Interim Long-Term Care Beds
Lead: Southlake Residential Care Village/York Central Hospital
In the fall of 2009, Central LHIN funded 32 new interim long-term care beds at Southlake Residential Care Village and 32 at York Central Hospital to reduce the number of people waiting in acute care beds for long-term care placement, and in turn positively impact the percent of alternate level of care days for Central LHIN as a whole.

Making Progress through our Integrated Health Service Plan

In 2009/10, Central LHIN continued to direct available resources towards making progress in the priorities identified in our IHSP 2007-2010.

We also consulted with hundreds of health care professionals, community leaders and members of the public to develop our IHSP 2010-2013, *Creating Caring Communities, Healthier People...Together*, which outlines four priorities we will focus on in the next three years.

Our new plan builds on the successes and achievements of our first IHSP, and continues to support the priorities of the Ministry of Health and Long-Term Care, in order to link provincial resources to local needs.

Supporting seniors and addressing emergency department wait times and alternate level of care pressures

In 2007, the Ministry of Health and Long-Term Care announced that $700 million would be available over three-years to improve integration of the community care system for seniors in Ontario . In total, Central LHIN will allocate about $100 million under Aging at Home:

Year	Investment*
2008/09 (Year 1)	$13.5M
2009/10 (Year 2)	$33.6M
2010/11 (Year 3)	$52.9M**

* Base increases to the system.
** Year 3 funding has yet to be confirmed

In 2009/10, Central LHIN continued to develop a more sustainable health system for seniors by:

- supporting provincial priorities to reduce emergency department wait times and alternate level of care pressures,
- leveraging Aging at Home to support IHSP priorities,
- building service capacity,
- addressing gaps in seniors care,
- strengthening linkages between our health service providers and community leaders outside the traditional health sector,
- supporting disadvantaged and underserviced groups and
- targeting opportunities that support our MLAA indicators and Ministry priorities..

The following are some initiatives we funded through Aging at Home in 2009/10.

Increasing Community Supports in Rural Areas Lead: Community Home Assistance to Seniors

This program expands service options in rural and underserved areas in the northern part of Central LHIN to provide seniors with more support to remain at home, to avoid unnecessary emergency department use and to reduce the number of days spent in acute care beds waiting for alternate levels of care.

Services include wellness programs, an Alzheimer's day program, home assistance, home maintenance, caregiver support and education, meals on wheels, transportation, respite care, social visiting and safety.

Adult Day Program for Seniors with Dementia Lead: Circle of Care/Baycrest Centre

This adult day program is available for Jewish seniors with dementia and developmental disabilities.

Services include:

- caregiver and family respite and support,
- escorted transportation,
- kosher meals and snacks,
- culturally and linguistically sensitive programs geared to cognitive ability, and
- access to bathing and other home supports.

Traditional Supports for Aboriginal Seniors
Lead: Lance Krasman Centre

The goal of this project is to both honour and support seniors of Aboriginal descent who are aging at home in York Region, by providing access to traditional ceremonies, medicines and community elders, while acknowledging traditional roles and providing opportunities to celebrate those roles.

The elders associated with this project will provide healing circles, seasonal feasts and traditional stage ceremonies. This project also involves in-home support from Aboriginal youth to seniors, and knowledge transfer – for example in relation to crafts, cooking, drumming, singing and stories – to Aboriginal youth from seniors as they celebrate their rightful place in the community circle.

Georgina Island Support for Independent Living
Lead: Chippewas of Georgina Island

This project aims to improve the quality of life for elders living on Georgina Island who require transportation for a variety of reasons, and who cannot afford private transportation when no public transportation is available.

Under this program, seniors are provided with transportation to medical appointments such as cancer treatments or regular illness monitoring, grocery stores and to other daily living supports.

CrossLinks Housing and Support Services
Lead: LOFT Community Services

LOFT Community Services is a mental health and addictions community agency providing supportive housing for seniors living with mental health and addictions-related issues in the North York West planning area.

Aging at Home at a Glance

In 2009/10, we invested $33 million through 53 projects to address emergency department and alternate level of care pressures. Highlight include:

- Implemented first Balance of Care program, which served 400 clients in the community
- Created 64 new interim long-term care beds
- Enhanced rehabilitation services to include weekend admissions, resulting in 146 additional patients admitted, and expanded outpatient services, serving 215 new patients
- Expanded CCAC-led in-home medication management program LHIN-wide
- Launched centrally managed nurse-led outreach program to long-term care, involving all of our hospitals and the Regional Geriatric Program of Toronto
- Initiated mental health and addictions emergency diversion program
- Developed LHIN-wide in-home palliative care education and assessment program
- Increased community support sector capacity, resulting in:
  - 10,474 one-way transportation rides
  - 1,698 meals
  - 5,748 caregiver support hours
  - 50 supportive housing units
- 320 full-time equivalent staff hired by our health service providers

The initial program, funded through Aging at Home, resulted in 53 seniors being placed into supportive housing, with an additional 80 clients living in the community with the help of supportive services delivered in their homes.

This expansion provided funding to add a short-term transitional program to place 16 mental health patients in an enhanced supportive

housing environment in preparation for reintegration into the community and provide new supportive housing and case management services for 76 seniors living with mental illness and addictions issues in the community.

Overall, this expansion resulted in provision of supportive housing services to 133 seniors.

Balance of Care
Lead: Central Community Care Access Centre
In 2009/10, Central LHIN invested just over $6 million in base and one-time funding to continue and expand the Balance of Care Program.

This program aims to reduce the number of people waiting in an acute care setting for placement into long-term care by building capacity in the community support service sector to deliver homemaking services to lower-acuity clients on the long-term care wait list.

This enables the CCAC to focus on higher-acuity clients by partnering with community agencies to deliver cost-effective services to seniors in need of personal support.

Chronic disease: tackling a growing and expensive health care challenge

Treatment for diabetes and related conditions – including heart disease, stroke and kidney disease – places significant demands on our acute care system and community-based services. It is also very costly. Unfortunately, chronic disease is on the rise in Central LHIN.

For example, we anticipate a 67% increase in the number of people with diabetes over the next 10 years – from 51,463 to 86,000.

Central LHIN is committed to improving access to diabetes care by supporting the roll-out of the Ontario Diabetes Strategy, streamlining the delivery system and putting a plan in place to support self-management.

2009/10 successes in this area include:

- **Central LHIN's Chronic Disease Self-Management Working Group released its Final Report:** *Chronic Disease Self-Management Capacity Building Initiative for Primary Care Health Professionals.*
- An $8 million expansion for 24 dialysis machines to open the **Vaughan Satellite Dialysis Unit at York Central Hospital**
- **Two new diabetes education teams** were announced for our LHIN, one at the Black Creek Community Health Centre and one at Southlake Regional Health Centre

Enhancing mental health and addictions services

Linking people with mental health and addictions-related issues to the supports they need is an ongoing challenge.

By continuing to make mental health and addictions a priority through our new IHSP, we can focus resources where they make the greatest impact – coordinating care and bridging gaps in the system, reducing wait times for assessment and services and enhancing community supports to reduce the burden of mental health and addictions on emergency departments and alternate level of care beds in hospitals.

2009/10 successes in this area include:

- **North York General Hospital Emergency Department Diversion Program:** This initiative focuses on improving the coordination of care delivery between acute care and community-based supports for mental health clients.
- **Anti-Stigma Project**: This education workshop project was one of 16 chosen to be featured by the Mental Health Commission of Canada, as part of its new 10-year anti-stigma / anti-discrimination initiative, *Opening Minds*. The initiative is the largest systematic effort to reduce the stigma of mental illness in Canadian history.

- **Cultural Competency Project:** The Central LHIN Mental Health and Addictions Diversity Workgroup released a Cultural Competency Project final report, which provides an overview, as well as findings and recommendations, of Central LHIN's 13-month Cultural Competency Project.

Supporting neurological services

Central LHIN residents requiring care for neurological-related conditions – such as stroke, acquired brain injury, or Alzheimer's disease– require timely access to appropriate care and services.

We have focused Aging at Home investments and other resources towards this goal.

2009/10 successes in this area include:

- **Adult day programs**: for seniors with dementia, including programs run by Circle of Care, Community Home Assistance to Seniors and the Alzheimer's Society of York Region
- **Funding for stroke prevention and health promotion clinics**: located in Central LHIN acute care hospitals, led by York Central Hospital, and the District Stroke Centre.
- **One-time investments in community-based Acquired Brain Injury Services**: with a view toward an ongoing investment in the following year, and building on the 2009 provincial vision

For progress on wait times see pages 9-10 and emergency services see page 12.

Keeping the "Local" in the LHIN

Engaging with our health service providers, communities and strategic partners is our mandate as a local health integration network; it is inextricably linked to the value we see in supporting community-level participation in health system decision-making.

In 2009/10, much of our engagement revolved around the development of our IHSP 2010-2013, *Creating Caring Communities, Healthier People... Together.*

We consulted with hundreds of health care professionals, community leaders and members of the public to develop this new strategic plan.

We also engaged with ministries other than the Ministry of Health and Long-Term Care, to better understand system impacts.

Finally, we continued to work to develop and foster positive relationships with individuals and groups with a stake in our health care system, to ensure we keep the "local" in the LHIN.

Connecting with our Aboriginal population

Central LHIN's Aboriginal community is a focus of targeted investments and activities under our Aging at Home strategy and the health equity priority of our new IHSP.

In 2009/10, Central LHIN held two engagement sessions with our Aboriginal population to continue to learn more about the unique needs and health priorities of this community.

Dialogue and collaboration: keys to effective Aboriginal patient care – In the fall of 2009, Central LHIN hosted a workshop for health service providers and representatives from the Aboriginal community to discuss Aboriginal health issues.

This was the first time health service providers and the Aboriginal community have come together to develop recommendations to improve Aboriginal health services.

The recommendations that came out of this session are the foundation of a report that will be used as a planning tool for the LHIN to align with our IHSP and Annual Business Plan.

Greater Toronto Area LHINs: strengthening the circle workshops – In March 2010, the GTA LHINs and the Aboriginal community came together for a second occasion to network and discuss relationship-building and future engagement approaches and to build knowledge on Aboriginal health in an urban environment.

We plan to keep working with our health service providers to enhance our Aboriginal engagement strategies, improve relationships and encourage collaboration across our health sectors.

Connecting with our Francophone population

Under the new provincial definition, about 56,000 people – approximately 3.2 % of our LHIN's population – is Francophone.

In 2009/10, we engaged with our Francophone community to receive input into the priorities of our new IHSP, and to continue to identify the French language service capabilities of our health service providers.

Two engagement sessions were held to:

- share information about our activities,
- validate our IHSP 2010-2013 priorities,
- discuss concerns regarding accessibility and capacity of French language services and
- continue our ongoing dialogue around how to achieve a shared vision for French language services in Central LHIN.

In recognition of the importance of access to information in French, we worked to improve the accessibility of information – in particular on our website – through increased translation of key materials (such as our IHSP, Health Service Needs Assessment and Gap Analysis Report and LHIN-Health Service Provider Governance Resource and Toolkit for Voluntary Integration Initiatives) – the launch of an online translation tool and through the development of a distinct French language services section on our site.

Engaging our primary care providers

Although Central LHIN does not fund most primary care providers, we remain committed to engaging and collaborating with this group in recognition of the important role they play in the health care system.

In addition to hosting quarterly meetings with our Health Professional Advisory Committee, Central LHIN welcomed its first partnership coordinator, as part of the HealthForceOntario Marketing and Recruitment Agency's Community Partnership Program.

Our coordinator works closely with our physician engagement and health human resources lead to support our engagement efforts.

In 2009/10, three engagement sessions – including a continuing medical education-credited session open to all Central LHIN family physicians – were held with primary care providers around the development of our new IHSP:

Talking to our citizens

As a key component of our engagement around the development of our IHSP 2010-2013, Central LHIN convened a Citizens Reference Panel to gather feedback from community members from across our LHIN.

Thirty members of various race, gender, age and geographical location were chosen from a lottery to participate on the panel.

Three full-day sessions were held in May, June and September 2009. Each session included a presentation from the LHIN on our IHSP priorities, followed by a presentation from a health service provider.

Each event concluded with a breakout session that provided panel members the opportunity for focused discussions on what they thought were the key components to a good health care system and how that aligned with the development of our IHSP.

Following each event, a report was prepared for consideration by our IHSP Steering committee and LHIN staff.

Community engagement framework for health service providers

Over the past year, our hospitals and community support providers came together with us to develop a community engagement framework to support their engagement activities.

As part of Schedule B of their accountability agreement, each hospital submitted an annual plan outlining planned community engagement activities – including goals, audiences, methods and results– and reported their progress on a quarterly basis.

Engaging with local government

In addition to connecting on an as-needed basis with our MPPs and municipal governments to answer constituency questions and to share information, Central LHIN hosted both our annual MPP breakfast and our annual Municipal Forum.

These sessions gave Central LHIN's leadership team and Board of Directors the opportunity to meet with local government representatives to update them on our activities and priorities, build stronger relationships and continue our ongoing dialogue on local health issues and our shared commitment to improving the health system for the residents of our LHIN.

Building local governance

Central LHIN recognizes the importance of good governance as a fundamental requirement for organizations as they operate in the complex health care environment.

We are committed to promoting and supporting health service provider boards to come together to dialogue, share best practices and learn from one another.

In 2009/10, Central LHIN held two rounds of four Governance Council meetings at various locations throughout the LHIN, geared to developing governance-level relationships between our board and the chairs of our health service provider boards.

These sessions help to keep board chairs apprised of Central LHIN's actions and investments, and enable participants to discuss governance-level priorities and opportunities for collaboration.

Central LHIN also sponsored 20 health service provider board members to attend a governance conference, which provided an overview of the current challenges faced by the not-for-profit sector, along with governance processes and structures to support board performance.

Special Initiatives

Vision for hospital services in Vaughan

In late 2008, the Minister of Health and Long-Term Care awarded a capital planning grant to Central LHIN to develop a master program for Hospital Services in Vaughan.

This was the first time a LHIN was asked to conduct this type of health service planning.

To engage and coordinate the input of the many groups and individuals who had an interest in the project, we formed a Stakeholder Liaison Group. Members included representatives from our hospitals and CCAC, the Vaughan Community Health Centre, the Vaughan Health Campus of Care and York University.

In the summer of 2009, we engaged with many of our health service providers and other stakeholders such as emergency medical services and several Toronto teaching/specialty hospitals regarding how they envisioned health delivery systems, with particular emphasis on cross-sector partnerships and integration opportunities.

During this time, York Central Hospital and Vaughan Health Care Foundation moved to restructure and enhance their collaborative efforts to build service capacity in Vaughan.

Our Vision for Hospital Services in Vaughan report, approved by our board and submitted to the Ministry of Health and Long-Term Care in November 2009, captured the work done to date for Vaughan hospital services planning, and will be a valuable resource as planning continues under the guidance of York Central Hospital, which has been given a $7 million planning grant from the Ministry.

eHealth: progress on a key enabler

Increasing the use of technology in health care can improve the overall care process, enhance the exchange of information across the health system and support individuals' participation in their own health care. eHealth is also a key enabler to achieving the priorities of Central LHIN's IHSP 2010-2013.

As part of our joint eHealth strategy with Toronto Central LHIN – released in summer 2009 – our LHIN launched some key eHealth programs this year that will change the way health care is delivered to local residents:

Resource Matching and Referral: Central LHIN is one of seven LHINs that partnered to undertake early adoption planning around an electronic information and referral system, which could improve patient transitions from one level of care to the next, based on a standardized and transparent assessment of the patient's needs.. Central LHIN developed a business case to assess anticipated benefits.

ConnectingGTA : This five-LHIN program will enable the exchange of clinical information across the continuum of care in the GTA by linking data systems and sources such as patient or disease registries, lab results and drug information, and enhance health professionals' access to timely and important information about their patients/clients.

Diagnostic Imaging Repository: All six of Central LHIN's acute care hospitals are involved in one of two diagnostic imaging repository initiatives, which support sharing of images locally, regionally and provincially, and will provide "Any Place, Anywhere" viewing of diagnostic images through a standardized imaging repository viewing application.

Central LHIN's Operational Performance

Two components made up Central LHIN's 2009/10 expenses:

Operations: $4.5 million

Special Projects: $1.3 million

Operations

The table to the right shows the 10 major categories of expenditure for our LHIN. Approximately 64% of the $4.5 million operations expenses related to Central LHIN's salaries and benefits. Almost 8% of the expenses related to Central LHIN's share of expenses for the LHIN Shared Services Office, which provides payroll, and technology, legal and human resource services for all 14 LHINs.

Central LHIN 2009/10 Operational Expenses	
Salaries and Wages	$2,967,561
Other	$218,417
Occupancy	$196,643
Consulting Fees	$224,282
Board	$190,032
Shared Services	$375,000
Public Relations	$63,984
Supplies	$56,601
Amortization	$194,528
Communication	$49,925
Total*	**$4,536,973**

Special projects

Central LHIN also received one-time funding to undertake planning and development for seven special projects during the 2009/10 fiscal year. These included:

Project	Funding allocation
Aging at Home	$300,000
Aboriginal Engagement	$31,596
Diabetes	$25,000
eHealth	$600,000
Emergency Department Lead	$75,000
Emergency Room-Alternate Level of Care	$100,000
French Language Services	$11,958
Vaughan	$215,000
Total	**$1,358,554**

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Auditors' Report

To the Members of the Board of Directors of the
Central Local Health Integration Network

We have audited the statement of financial position of the Central Local Health Integration Network (the "LHIN") as at March 31, 2010 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Central Local Health Integration Network as at March 31, 2010 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
April 30, 2010

Membre de / Member of Deloitte Touche Tohmatsu

Central Local Health Integration Network

Statement of financial position
as at March 31, 2010

	2010	2009
	$	$
Financial assets		
Cash	**659,837**	605,733
Due from Ministry of Health and Long-Term Care ("MOHLTC")	**3,103,069**	5,981,119
Due from LHIN Shared Services Office (Note 4)	**3,643**	-
Accounts receivable	**66,633**	98,470
	3,833,182	6,685,322
Liabilities		
Accounts payable and accrued liabilities	**680,303**	683,054
Due to Health Service Providers ("HSPs")	**3,103,069**	5,981,119
Due to the LHIN Shared Services Office (Note 4)	**-**	21,149
Deferred Revenue	**54,042**	-
Deferred capital contributions (Note 5)	**205,188**	325,793
	4,042,602	7,011,115
Commitments (Note 6)		
Net debt	**(209,420)**	(325,793)
Non-financial assets		
Prepaid Expenses	**4,232**	-
Capital assets (Note 7)	**205,188**	325,793
	209,420	325,793
Accumulated surplus	**-**	-

Approved by the Board

Ken Morrison
Director

Director

Central Local Health Integration Network

Statement of financial activities
year ended March 31, 2010

	Budget (unaudited) (Note 8)	2010 Actual	2009 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	1,622,253,700	1,671,803,309	1,579,748,869
Operations of LHIN	4,259,237	4,344,422	4,073,224
E-Health (Note 10a)	-	600,000	483,700
Emergency Room/Alternative Level of Care ("ER - ALC") Funding (Note 10b)	-	100,000	33,300
Aging at Home Funding (Note 10c)	-	300,000	-
Aboriginal Initiative (Note 10d)	-	30,000	47,088
Vaughan Hospital Study (Note 10e)	-	215,000	-
Emergency Department Lead (Note 10f)	-	75,000	75,000
Diabetes Strategy (Note 10g)	-	25,000	-
French Language Services (Note 10h)	-	11,958	-
Amortization of deferred capital contributions (Note 5)	-	194,528	164,044
	1,626,512,937	1,677,699,217	1,584,625,225
Expenses			
Transfer payments to HSPs (Note 9)	1,622,253,700	1,671,803,309	1,579,739,110
Operations			
General and administrative (Note 11)	4,259,237	4,536,973	4,237,268
E-Health (Note 10a)	-	600,000	483,700
ER - ALC funding (Note 10b)	-	100,000	33,300
Aging at Home Funding (Note 10c)	-	300,000	-
Aboriginal Initiative (Note 10d)	-	31,596	47,088
Vaughan Hospital Study (Note 10e)	-	215,000	-
Emergency Department Lead (Note 10f)	-	75,000	75,000
Diabetes Strategy (Note 10g)	-	25,000	-
French Language Services (Note 10h)	-	11,958	-
	1,626,512,937	1,677,698,836	1,584,615,467
Annual surplus before funding adjustments for unallocated in year recoveries from HSP's	-	381	9,759
Adjustments for unallocated in year recoveries from HSP's (Note 3)	-	-	(9,759)
Operations annual surplus	-	381	-
Funding repayable to the MOHLTC regarding operations (Note 3)	-	(381)	-
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Central Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2010

	Budget (unaudited) (Note 8)	2010 $	2009 $
Annual surplus	-	-	-
Acquisition of capital assets	100,000	73,922	186,091
Amortization of capital assets	(210,890)	(194,527)	(164,044)
Change in other non-financial assets	-	4,232	-
Decrease in net debt	(110,890)	(116,373)	22,047
Opening net debt	325,793	325,793	303,746
Closing net debt	214,903	209,420	325,793

Central Local Health Integration Network

Statement of cash flows
year ended March 31, 2010

	2010	2009
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**(194,527)**	(164,044)
Amortization of deferred capital contributions (Note 5)	**194,527**	164,044
	-	-
Changes in non-cash operating items		
Decrease (Increase) in due from MOHLTC	**2,878,050**	(2,926,199)
Decrease (Increase) in accounts receivable	**31,837**	(95,745)
(Decrease) Increase in accounts payable and accrued liabilities	**(2,751)**	81,085
Decrease increase in due to the MOHLTC	-	(70,733)
(Decrease) Increase in due to HSPs	**(2,878,050)**	2,926,199
(Decrease) Increase in due to the LHIN Shared Services Office	**(24,792)**	19,305
Increase in deferred revenue	**54,042**	
Increase in prepaid expenses	**(4,232)**	-
	54,104	(66,088)
Capital transactions		
Acquisition of capital assets	**(73,922)**	(186,091)
Financing transactions		
Deferred capital contributions received (Note 5)	**73,922**	186,091
Net increase (decrease) in cash	**54,104**	(66,088)
Cash, beginning of year	**605,733**	671,821
Cash, end of year	**659,837**	605,733

1. Description of business

The Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and the amounts transferred to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2008.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers most of North York, York Region and South Simcoe. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, and they are measurable. Expenses include non-cash items, such as the amortization of capital assets; and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN financial statements do not include any MOHLTC managed programs, where the HSP is directly accountable to the MOHLTC.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and the reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund capital asset purchases, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment and development	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

Excess funding from the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	2010 Surplus	2009 Surplus
	$	$	$	$
Transfer payments to HSPs	**1,671,803,309**	**1,671,803,309**	**-**	9,759
LHIN operations	**4,538,950**	**4,536,973**	**1,977**	-
Special Program Funding	**1,356,958**	**1,358,554**	**(1,596)**	-
	1,677,699,217	**1,677,698,836**	**381**	9,759

LHIN activities show a surplus of $381 (2009-$9,759)which will be recovered by MOHLTC in the next fiscal year.

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN. The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

LHIN Cooperative (LHINC) was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The full costs of providing these services are billed to all the LHINs as well as supported by funding from MOHTLC.

5. Deferred capital contributions

	2010	2009
	$	$
Balance, beginning of year	**325,793**	303,746
Capital contributions received during the year	**73,922**	186,091
Amortization for the year	**(194,527)**	(164,044)
Balance, end of year	**205,188**	325,793

6. Commitments

The LHIN has commitments under various operating leases as follows:

	Office space	Equipment	Total
	$	$	$
2011	264,187	7,936	272,123
2012	22,016	2,090	24,106

The LHIN enters into accountability agreements with HSP's which include planned funding targets. The actual amounts which will ultimately be paid to HSP's are contingent on LHIN funding received from the MOHLTC.

7. Capital assets

	Cost	Accumulated amortization	2010 Net book value	2009 Net book value
	$	$	$	$
Office furniture and fixtures	271,950	193,206	78,744	113,491
Computer equipment	104,270	43,009	61,261	38,160
Leasehold improvements	506,768	441,585	65,183	174,142
	882,988	677,800	205,188	325,793

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2009. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $ 1,672,186,673 is made up of the following:

	$
Initial HSP	1,621,870,336
Budget	-
Adjustments due to announcements made during the year	49,932,973
	1,671,803,309

The total budget by sector is as follows:

Operation of Hospitals	1,051,676,778
Grants for Municipal Taxation	224,925
Long Term Care Homes	281,643,069
Community Care Access Centres	203,474,565
Community Support Services	36,960,752
Acquired Brain Injury	8,938,225
Assisted Living Services in Supporting Housing	19,436,492
Community Health Centres	7,105,587
Community Mental Health	57,928,353
Addictions Program Initiatives	4,414,563
Total budget	1,671,803,309

The original LHIN operating budget was $4,259,237. Additional program funding in year resulted in a year-end budget of $5,810,028 made up of the following:

8. Budget figures (continued)

	$
Initial budget as reported on the statement of financial activities	4,259,237
Additional funding received in-year:	
Funding for capital asset purchased transferred to deferred capital contributions	(73,922)
Funding transferred from deferred capital contributions	194,528
Stabilization	85,185
Special programs	
E-health	600,000
Vaughan Capital Study	215,000
Diabetes	25,000
Aging at Home	300,000
Aboriginal Initiative	30,000
Emergency Response - Alternate Level of Care	100,000
Emergency Department Lead	75,000
Closing budget	5,810,028

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $1,672,186,673 (2009 - $1,579,748,869 of which $9759 was unallocated) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2010 as follows:

	2010	2009
	$	$
Operation of Hospitals	**1,051,676,778**	1,002,538,075
Grants to compensate for Municipal Taxation - Public Hospitals	**224,925**	216,450
Long Term Care Homes	**281,643,069**	266,837,701
Community Care Access Centres	**203,474,565**	188,132,222
Community Support Services	**36,960,752**	31,105,167
Acquired Brain Injury	**8,938,225**	8,561,178
Assisted Living Services in Supportive Housing	**19,436,492**	18,652,036
Community Health Centres	**7,105,587**	4,897,912
Community Mental Health	**57,928,353**	54,504,178
Addictions program	**4,414,563**	4,294,191
	1,671,803,309	1,579,739,110

10. a) E-health

The LHIN received funding of $ 600,000 (2009 - $483,700) related to the E-health project. E-health expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and benefits	**484,929**	288,600
Consulting services	**55,761**	145,960
Accommodation and administration	**52,950**	48,001
Supplies and other	**6,360**	1,139
	600,000	483,700

b) Emergency Response - Alternate Level of Care (ER-ALC)

The LHIN received funding of $100,000 (2009 - $33,300) for the Emergency Response – Alternate Level of Care project in the 2010 fiscal year. The following are the expense details:

	2010	2009
	$	$
Salaries and benefits	**85,431**	29,364
Accommodation and administration	**11,005**	3,652
Supplies and other	**3,564**	284
	100,000	33,300

c) Aging at Home

The LHIN received one time funding of $300,000 for the Aging at Home projects in 2010 fiscal year. In 2009, the LHIN entered into a Shared Cost Agreement with the Central CCAC for up to $ 364,000 to deliver incremental costs associated with Aging at Home Planning incurred on behalf of the CCAC for the 2009 fiscal year. Expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and benefits	**280,319**	233,064
Public relations	**3,300**	13,449
Consulting services	**-**	9,950
Supplies	**1,788**	218
Other	**14,593**	7,855
Recoveries	**-**	(264,536)
	300,000	-

10. (continued)

d) Aboriginal initiative

The LHIN received funding of $ 30,000 (2009 - $47,088) related to the Aboriginal Planning initiative. Expenses incurred during the year are as follows:

	2010	2009
	$	$
Consulting services	30,122	46,167
Supplies and other	1,474	921
	31,596	47,088

e) Vaughan Hospital study

The LHIN received one time funding of $215,000 for the Vaughan Hospital Study. Expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and benefits	69,301	-
Consulting services	141,144	-
Public relations	3,993	-
Supplies and other	562	-
	215,000	-

f) Emergency department (ED) lead project

The LHIN received funding of $ 75,000 (2009 - $75,000) related to the ED Lead project. ED Lead project expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and benefits	15,000	15,000
Consulting services	60,000	60,000
	75,000	75,000

g) Diabetes strategy

The LHIN received one time funding of $ 25,000 related to the support service expansion for the diabetes strategy. Expenses incurred during the year are as follows:

	2010	2009
	$	$
Salaries and benefits	25,000	-
	25,000	-

10. (continued)

h) French Language Services

The LHIN is expecting to receive one time funding of $66,000 related to support Francophone community engagement activities. $11,958 has already been spent with the remaining balance to be spent in fiscal year 2011. Expenses incurred during the year are as follows:

	2010	2009
	$	$
Public relations	9,473	-
Consulting services	2,485	-
	11,958	-

11. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2010	2009
	$	$
Salaries and benefits	2,967,561	2,678,888
Occupancy	196,643	221,466
Amortization	194,527	164,044
Shared services	375,000	300,000
Public relations	63,984	109,350
Consulting services	224,282	288,534
Supplies	56,601	67,401
Board expenses (see note below)	190,032	200,221
Mail, courier and telecommunications	49,925	53,132
Other	218,418	154,232
	4,536,973	4,237,268

Note:

	2010 budget	2010	2009
	$	$	$
Board Chair per diem expense	50,400	47,775	55,300
Other Board members per diem expense	89,600	78,750	74,999
Governance costs and travel	64,000	63,507	69,922
	204,000	190,032	200,221

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 23 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2010 was $ 228,911 (2009 - $200,455) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2009. At that time, the plan was 102% funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

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Finding out more about how Central LHIN is working to improve health care in our local communities is just a click away at

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